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Price Controls or Managed Competition? Lessons for California

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Setting Medical Prices: The Return of Rate Regulation

In recent years, policymakers and health reformers have focused on reducing the unit cost of medical goods and services to contain high and rising health care spending, especially in the private sector. One prominent example of this trend toward regulating prices is legislation taken up, but not passed, by the California State Legislature in 2018 that would have created an appointed commission to set commercial health care prices in the state.¹

The focus on direct cuts to health care prices has come to the fore for several reasons. It reflects the academic consensus that high prices, not greater utilization of services or other reasons, is the main factor that drives U.S. per capita health spending far above that of other countries. A large discrepancy has grown between what commercial payers pay for medical care and reimbursement rates from Medicare, Medicaid, and other government programs. This appears to reflect, in large part, the consolidation of hospitals and medical practices

into larger groups that can negotiate higher prices from employers and health insurers.

Because companies have increased the number of employees in high-deductible plans and passed on a greater share of their health costs to employees in the form of co-payments, these cost increases are much more visible to workers. Unsubsidized buyers in ACA marketplaces are facing a similar quandary. While access to care, a previous source of anxiety for consumers during the rise of managed care, is less often on the front burner, considerable anger has built over high charges for emergency room treatment, care provided (but often not disclosed in advance) by out-of-network providers, and charges that deviate widely from regional averages.

Though efforts to regulate medical prices have been tried before, doing so in the private sector departs from the main health cost-containment ideas included in the Affordable Care Act, such as Accountable Care Organizations and bundled payments, which reforms try to redesign care delivery to reduce the provision of unnecessary or harmful care, rather than directly addressing prices.

Direct government regulation of health care prices has a long history at the state and federal level, as well as overseas. During the early 1970s, for example, around one-third of U.S. states engaged in some kind of price regulation of hospitals. Most states backed away from these controls in the 1980s as managed care and competition among health plans became more common, and because new federal regulations inadvertently undercut price controls. Medicare, through its prospective payment system to hospitals, engages in another form of administered pricing. The Clinton Health Plan included price controls, in the form of premium caps, as a fallback plan if intended competition between health plans failed to materialize.² Most industrialized countries, such as France, Germany, and Japan practice some kind of rate regulation alongside global budgets and national health insurance programs.

This report examines the ongoing, mostly state-based efforts aimed at lowering health care prices: Maryland's all payer system; Massachusetts' health commission and its non-binding price targets; Colorado's ballot initiatives aimed at greater price transparency, and direct contracting with providers by employers. It asks whether there are lessons California can learn from these experiments as well as limitations to importing similar practices into California and expecting the same results. It asks, finally, if reinventing managed competition—a “made in California” alternative³ that tries to reduce total health care costs while improving quality of care—has the potential both to moderate prices and avoid the drawbacks of price controls.

Turning to price controls runs against the grain of both orthodox economics and American preferences for markets. Such constraints tend to be resorted to when markets are felt to have broken down entirely (as many argue is the case in U.S. health care⁴), or when government and other payers feel compelled for fiscal reasons to impose spending limits.

Stanford University's Alain Enthoven, who pioneered the

concept of managed competition—in which regional purchasers choose among competing managed care systems—once wrote that “the only proved method for bringing the growth in total expenditures into line with the gross national product is for government to take over most of health care financing and place it under firm global budgets.”⁵

Nevertheless, Enthoven concluded that “in view of our historic preference for limited government and decentralization,” it would be both more prudent and more in keeping with American tradition to construct a set of private, market-based systems. The marketplaces under the Affordable Care Act are closely related to this vision.

Maryland's All Payer Rate-Setting Hospital System and Global Budget

Maryland's hospital all payer system lasted from 1977-2012. Like many similar rate setting state programs at the time, it depended on a federal waiver that permitted higher Medicare payments than the national norm. Studies showed that the most successful of these programs—those in New York, New Jersey, Massachusetts, and Maryland—may have reduced hospital prices by around 10-15 percent.⁶ In 2012, this Maryland program was replaced by the introduction of global budgets under a new federal waiver, but one which relied on the earlier all-payer structure to win medical industry and public support.⁷

In the early 1970s, Maryland was experiencing a period of unusually high and rising health care costs, large Medicaid deficits, and high levels of uncompensated care stemming from high use of care among poor urban residents. Maryland does not have any government-run public hospitals, which means that indigent care is delivered primarily in private hospitals.

Moving to an all-payer system created better access,

lowered the amount of uncompensated care owed to hospitals, and slowed the rate of growth in hospital costs while offering transparency in charges. Over the thirty-year period from 1976 to 2005, Maryland had the second lowest rate of growth in cost per episode of care, though at the beginning of this period these costs were extremely high, at 25% above the U.S. average.

HSCRC, the commission formed in 1971, took almost six years to implement the all-payer system, which covered inpatient services in hospitals only. Prices varied somewhat between hospitals depending on the

population they served but all payments to individual hospitals were equalized. Policymakers discovered that when payment was equalized and capped that hospitals responded by increasing the volume of services and moving services outside the hospital. In response, the state implemented many types of volume controls that limited additional payments to the variable costs associated with new patients.

The major element that made the all-payer system in Maryland work, however, was the Medicare waiver that Maryland signed with the federal government. This

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Why U.S. Prices Are So High⁸

Americans pay more overall for health care than do residents of other developed countries in large part because of the higher prices they pay for every visit, procedure, test, or surgery. On average, Americans go to the doctor no more frequently than in other countries. However, the services they receive are more expensive and they frequently receive a more expensive mix of tests and procedures than in peer countries.⁹

In 2003, the late Uwe Reinhardt co-authored an important paper, "It's The Prices, Stupid!" that established the role of high prices as the distinguishing factor in high U.S. health care costs.¹⁰ A landmark 2007 study by the McKinsey Global Institute found that the US spent what it termed an "excess" \$477 billion (in 2003 dollars) on health care after accounting for the fact that richer countries spend more on health care. The McKinsey authors found this excess spending concentrated in hospital care, administration, and outpatient services. In each of these particular cases, the higher prices of the inputs—from supplies to labor costs—was the principal cause of higher spending, rather than an aging population or a

higher rate of illness or injury among Americans.¹¹ More recently¹² a 2018 JAMA study comparing the U.S. with ten other developed countries found that the U.S. had similar utilization rates as in the other nations but spent roughly twice as much on medical care; it pointed to the price of labor, medical supplies, and prescription drugs, as well as administrative costs, as the main difference.¹³ Researchers from UCLA and the Institute for Health Metrics, based on a study of seventeen years of personal U.S. health spending, found that this spending grew from \$1.2 trillion to \$2.1 trillion from 1996 to 2013, or some 1.6 percent faster than the economy as a whole. This study concluded that almost two-thirds of this increase in spending reflected what took place during health care visits and hospital stays and the prices of services, tests, and procedures.¹⁴ Finally, the Health Care Cost Institute found that except for prescription drugs the utilization of hospital, outpatient, and professional services went down between 2012 and 2016 even as total health spending increased by fifteen percent, indicating strongly that the price of care was the principal cause.¹⁵

waiver allowed Medicare and Medicaid to pay the same rate as commercial payers, in other words exempting Maryland hospitals from having to accept lower Medicare rates. Maryland, moreover, successfully managed to place the waiver in federal statute in 1985, meaning that unless its payment per inpatient case grew faster than the U.S. average, only an act of Congress could overturn it. Having set the base year at a time when the state's Medicare spending was far above this average, even mediocre results subsequently meant that Maryland received a surplus payment of billions of dollars a year from the federal government.

Keeping some portion of this windfall was a strong motivating factor for Maryland hospitals to accept a new waiver that imposed global budgets beginning in 2014. As volumes decreased in the state and national Medicare payments per capita decreased as a result of the 1997 Balanced Budget Act, Maryland risked losing its waiver. In return for relinquishing its statutory basis, adding quality targets, committing itself to holding growth to a predetermined level, and accepting global budgets, it was granted a new waiver, with the expectation of a renewal in 2019.

In the first four years of global budgeting Maryland saved \$330 million for Medicare, although it was unclear whether this savings resulted primarily from the impact of the global budget or from a general slowdown in medical spending. Studies also suggested that savings were concentrated in rural hospitals and that applying global budgeting to hospitals might simply "squeeze the bubble" and drive the provision of care to outpatient settings.¹⁶

Massachusetts' Health Policy Commission (HPC)

By contrast, Massachusetts is a high-cost state for health care that also experienced some of its highest annual growth rates during the 1990s and 2000s. In fact, in 2009, Massachusetts had the highest spending per

capita in the nation. This reflects the state's very high proportion of teaching hospitals and several high-profile mergers that reduced competition and favored suppliers over payers in negotiating rates.

Through its landmark 2006 reforms Massachusetts also became the first state in the nation to reach near-universal health insurance coverage. The policymakers who backed this expansion explicitly stated that tackling health costs would be the next step on the agenda.

Unlike in Maryland, in which all the major hospitals and most of the industry players, save the single major insurer, had backed rate regulation, the large hospital systems, medical groups, and teaching hospitals in and around Boston were unlikely to back mandatory price setting of any kind. These providers deliver eighty percent of care in the state, a far higher percentage than average for the country.

In response, Massachusetts' Chapter 224 law, enacted in 2012, demanded a regime of comprehensive transparency that lacked, for the most part, any regulatory teeth. By publicizing prices and demanding explanations of actions that would threaten to push costs above a benchmark target, it relied on a combination of "naming and shaming" plus market pressure to bring down the level of prices, and costs.¹⁷

Massachusetts established two state agencies: the Health Policy Commission (HPC) which sets a health care growth benchmark, produces a report on cost trends annually, and conducts cost and market impact reviews; and the Center for Health Information and Analysis (CHIA), a research foundation that also maintains a database of claims and maintains a consumer website.

Much like Maryland, the Commission calculates a per capita measure of total state health care growth and sets a benchmark: however, it has no control over actual commercial rates. Since 2016, however, it can require performance reviews from providers whose actions, in its view, threaten to jeopardize the benchmark, and

in effect demand both an explanation and a plan for reversing the upward trend. Commissioners can also call for a full cost and market review of the impact of mergers (they have done so seven times since the inception of the Commission) which can result in recommendations that the Attorney General, for example, begin anti-trust proceedings, but “HPC does not on its own have ultimate power to stop any transaction.”

Although other factors, such as the state of the overall economy and medical cost trends, are surely involved, the Massachusetts Commission appears to have had a positive impact in moderating commercial market health cost trends in a state that was in many ways a poster child for runaway costs.¹⁸ In most years the growth in overall spending has been below the benchmark—for 2016, the last year data is available, overall growth was 2.8 percent, well below the 3.6 percent target.¹⁹ As the chair of the Commission and renowned health economist Stuart Altman remarked, “So far the commission is working pretty well...it’s worth a shot to see if we can make the system work better without imposing more rigorous and extensive government regulation.”²⁰

Colorado: A Price Transparency Debate?²¹

Colorado has taken an alternate approach in its attempts to reduce health care prices, focusing instead on price transparency. A slate of recently passed and proposed bills has taken aim at the secrecy surrounding the prices of health care services and medical procedures. The Transparency in Health Care Prices Act, signed into law in January 2018, requires that hospitals publish the self-pay prices of common procedures. The law’s supporters hope that such a measure will encourage consumers to shop around and compare prices at different facilities, which would in turn promote price competition between hospitals.²²

Another bill, introduced to the Colorado state legisla-

ture in spring 2018 and dubbed the Comprehensive Health Care Billing Transparency Act, would require hospitals to post lists of the prices of every procedure they do, as well as requiring insurance companies to publish the lower prices they negotiate with hospitals.

Though these initiatives aim to encourage health care providers to reduce the prices of their services by increasing transparency and competition, debate remains over whether they would be successful in this goal. Opponents argue that such a change might actually increase prices, since hospitals might not bid as competitively if they know what other providers are charging.²³ Given the recent passage of the Transparency in Health Care Prices Act and the uncertainty whether future bills will pass, it remains unclear what impact increased transparency will have on health care prices in Colorado.

Challenges for Price Transparency

However, as those with employer-based coverage increasingly are steered toward high-deductible insurance products and in general face increasing co-payments, their experience of “sticker shock” has added to the longstanding frustration of payers who can’t decipher how the prices of health care are determined and how these manifest themselves in rising premiums. This anger is helping drive the momentum toward price regulation. For example, the online journal Vox has been conducting a crowd-sourced inquiry into the facility fees charged by emergency rooms (in effect, the price of getting admitted before treatment is administered), which vary from a minimum of around \$500 to over \$3,000 with little apparent rhyme or reason.²⁴

Analysts suggest that making prices more transparent is a necessity for creating a less expensive and more efficient health delivery system. This theory stipulates that greater transparency would help patients calculate out-of-pocket costs and avoid this “sticker shock.” More

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Direct Contracting by Employers with Providers

After years of taking an arms-length approach to the health insurance plans they sponsor, large employers have moved, in effect, to take health benefits out of the HR department and put them squarely in the executive suite. These self-funded employers are increasingly demanding that the physicians and hospitals they contract with show explicit evidence of value, generally both in the form of lower costs and better outcomes. Some are taking modest steps in this direction by steering business toward ACOs and episode-based payments. Others are moving more aggressively toward direct contracting with physicians and integrated health systems, which combine a medical group with an insurer and take on full risk for the cost of treating patients.

In contrast to managed competition, a small but growing number of employers are bypassing insurers altogether to cut the least expensive deals with a network of high-value providers. As one quality improvement expert puts it, if fee-for-service payment is like buying a TV one part at a time, and bundled payment is like getting an assembled product, these newer and narrower employer-driven networks resemble a do-it-yourself assembly from a set of superior components.²⁵

For instance, Seattle-based Boeing has negotiated direct contracts with large integrated systems in four

markets—Seattle, St. Louis, Charleston S.C, and Los Angeles—for some 15,000 of its employees, or around one third of those eligible in those locations. Boeing and the health providers agree on a financial and performance guarantee in advance. The health care providers share in any savings that materialize. Boeing’s managers can also stipulate aspects of care they find important—like including behavioral health and primary care coordination—and can better customize the plans because its employee base is relatively stable and because (unlike in standard insurance plans) the provider has access to specific data on the employee population served. Since the program only launched in 2015, knowing the extent of cost savings is premature, but satisfaction among executives, participating providers, and employees is high.²⁶

Purchasers need not be as large as Boeing to realize the promise of direct contracting. Langdale Industries of Valdosta, Georgia, a rural wood products company, held its average increase per employee to 1.31 percent annually from 2000-2009, far below the national average of 8.83 percent over that time period, while keeping quality high. Its main strategy was to set up a firm that could figure out quality and cost data for individual providers, then aggressively court those providers and place them in a made-to-measure network.²⁷

transparent prices would help health plans to choose which providers to include in a network, “name and shame” providers that charge high prices, and allow providers to ensure that patients could afford the recommended care.²⁸

However, even were accurate prices available at the

point of service, there is no certainty—from a consumer perspective—that it would drive down health care costs. This is largely because there are few standards and even fewer well-known ones that allow consumers to compare price to value.²⁹ In the absence of trusted quality standards, people are often reluctant to choose less expensive providers, even with their own money at risk,

since higher prices in medicine continue to be seen by many as a proxy for better care.³⁰

Further challenges to price transparency include the gag or non-disclosure clauses included in many contract negotiations between health plans and providers, ostensibly to prevent the release of trade secrets, but mainly to preserve competitive advantage. Moreover, federal law exempts self-insured employers from having to disclose their claims to all-payer claims databases, which exist in some states but not nationally. Both of these roadblocks could be overcome by new legislation or by different interpretations of existing law.³¹

Despite these challenges, genuine progress has been made toward making public both the actual charges

and prices that hospitals charge for procedures and some sense of what the average price for procedures and tests may be in a particular geographic area. Consumer sites such as www.clearhealthcosts.com, Leapfrog Group, FAIRHealth, YouCanPlanForThis.org, MedicareCompare, HealthcareBlueBook.com, and NewChoiceHealth.com offer a far more complete and accurate picture of what hospitals actually charge than even a few years ago. In California, the Integrated Healthcare Association has compiled a detailed accounting of what hospitals charge in different rating regions. This database is increasingly refined.

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Provider Payment Rates: How Much Do They Differ?

Many hospitals and other medical facilities say they rely on higher commercial payments to offset much lower Medicare and Medicaid rates. While Medicare sets rates for hospitals based on a per-episode formula and for physicians based on a relative value scale (which is heavily weighted in favor of specialty care), commercial payers negotiate with providers over payments and their inclusion in plan networks. Medi-Cal establishes payment rates for physicians but engages in negotiations with hospitals.

Nationally, the average gap between commercial and both Medicare and Medi-Cal rates has been growing rapidly over the last twenty years, reflecting for the most part the increased consolidation of providers over that period and the greater bargaining power they have acquired. In the mid-1990s, commercial payers paid on average about 10-15 percent more than Medicare, but

this gap grew to 75 percent by 2012.³² However, these rates differ by hospital, by city, and by region. Many hospitals receive payments that far exceed this average. Based on a 2010 study of insurers in five large cities, the median inpatient commercial rate in Los Angeles was 118 percent of Medicare, while the median rate in San Francisco was 210 percent.³³

Nationwide, a small number of hospitals have a positive margin on fee-for-service Medicare patients, but most lose money on this group. These average margins were at -9 percent in 2017, down from -7.1 percent just two years earlier.³⁴ Hospital margins on Medicare Advantage enrollees, however, come much closer to commercial levels. Medicaid margins vary greatly because some hospitals specialize in treating low-income patients while others are less equipped to do so.

California's Health Care Marketplace and Its Challenges to Rate-Setting

California is a state with relatively low per capita health costs and a wide range in the variation of commercial rates, with health care regions that range from modestly competitive (Los Angeles and environs) to increasingly concentrated (much of Northern California).³⁵ When Maryland launched its all payer system, by contrast, it had very high per capita rates and much lower variation between commercial and government rates. Moreover, the federal government's willingness to adjust Medicare rates higher was the linchpin to making the whole system work for hospitals and physicians, just as the desire to keep these rates encouraged providers to accept global budgeting for hospitals.

By contrast, California Medi-Cal rates are extremely low, there is little or no chance of the state receiving a federal waiver to change either Medicare or Medi-Cal rates, and the gap between Medicare and commercial rates is very wide [See Text Box 2]. While the average difference nationally between commercial and Medicare rates is in the 1.5/1 percent range, the actual difference in some urban areas of California is in the 2:1 or 3:1 range. While some hospitals that have made their clinical care and administration more efficient could function on Medicare prices, as advocates of a "single price" argue, finding the sweet spot between a higher price that doesn't hurt consumers and a lower price that could undercut quality and innovation will be very challenging.

In California, there is a very strong correlation between health care market concentration and higher prices. California's hospital and physician markets overall are heavily concentrated, with forty-four of fifty-eight counties in the state ranking as concentrated according to standard measures. Northern California markets for hospitals and doctors in different specialties have far less competition than Southern California's, and medical prices vary

correspondingly. Inpatient prices were 70 percent higher and outpatient prices 17-55 percent higher, depending on physician specialty, in Northern California than in Southern California in 2016.³⁶ There is some evidence that higher prices are positively correlated with better outcomes. According to the Oakland-based Integrated Healthcare Association, which tries to measure quality relative to cost across the state using both commercial and public insurance claims, in general Northern California achieved high clinical quality measures but at a much higher cost, Southern California achieved good quality results at much lower costs, and Central California achieved generally weaker quality performance with mixed findings on costs.³⁷

Price targeting, rather than direct rate-setting, may be more appropriate for California, largely because the discrepancy between rates is so great and regional marketplaces are so distinct. Massachusetts—and in particular Boston with its high concentration of hospitals and teaching hospitals—more closely resembles the health care economy of the Bay Area. And there are good arguments for a price-targeting commission like that in Massachusetts, in which unusual price increases by hospitals must be explained and justified even if the Commission itself has no direct mechanism to reject them. The Commission can recommend taking further regulatory or anti-trust action if it deems it necessary and pass on these recommendations to the relevant authorities such as the Attorney General. However, as the Massachusetts example so far shows, hospitals and other providers have been willing to make modest price reductions so as not to run afoul of the Commission. The Commission and its companion institute also are creating the kind of data base necessary to back up a system that relies either on more government regulation, more competition, or some combination of competition in the future, with a very modest outlay of funds. It is worth noting that it took six years for Maryland's all payer system to get up and running from the time it was written into law.

Back to the Future? Reviving a More Competitive Health Care Marketplace in California

Rate setting proposals are often advanced as if they are a novel policy solution but, as this paper has documented, they have a long pedigree which provides uneven evidence that they would be effective in the United States if implemented again. Rate setting in the commercial sector originally lost favor in the 1990s as managed competition ascended.

Managed competition relies upon sponsors or brokers who act as purchasing agents for groups of individuals who share some of the financial consequences of choosing between different health plans. Consumers choose from a menu of standardized plans, which feature distinct provider networks, and pay a higher premium if they choose more expensive products.³⁸ As envisioned by Stanford's Alain Enthoven and other health economists, sponsors choose among organized delivery systems that combine a multispecialty group practice along with an insurance and financing arm, paid on a per capita rather than fee-for-service basis. Such pre-paid group practices – of which Oakland-based Kaiser Permanente, with its nine million enrollees, is the most prominent example – should discourage the tendency to overtreat inherent in fee-for-service and to have the necessary scale to allow continuity of care, dissemination of best practices, and ability to meet high standards of quality.³⁹

When it was possible to compare these different strategies head to head, an empowered network of private managed care plans appears to have been the more successful approach to lowering the healthcare cost trend, and the experience during this time did not even fully incorporate the structure of managed competition. Managed care plans, for a time, kept medical prices in check in states like California and several others, compared to more heavily-regulated states.⁴⁰ Glenn Mel-

nick and his UCLA colleagues estimated that the prices paid by commercial payers to California hospitals fell by twenty-six percent between 1995 and 1999 at the height of the initial widescale implementation of managed care.⁴¹ Similar trends, though less dramatic, took place nationally.⁴² However, healthcare prices then went up some 238 percent between 2002 and 2016, again a trend that was mirrored nationally.

What accounts for this reversal and what can be done about it? Current price control proposals are largely a response to a lack of competition in the marketplace, but their effectiveness in the United States was limited even when there were more competitive marketplaces. Managed competition, on the other hand, may have a better track record but also requires competition. How could California build on its existing landscape of regional networks of providers, of sponsors and plans to reinvigorate competition?

Fortunately, the California marketplace, in some respects, is evolving in ways that mirror the original promise of managed competition.⁴³ Covered California, the state's Affordable Care Act marketplace of some 1.3 million enrollees, operates as an active purchaser. It selects insurance plans that meet certain criteria, rather than accepting all comers. Unlike other states, it has standardized the benefit packages, co-pays, and deductibles that can be offered at each tier of coverage. In its first years of operation, the annual growth of premiums in Covered California was one of the lowest in the country. Private exchanges such as Southern California's Word & Brown's Cal Choice, which has operated for over twenty years in the small group market, also resemble the sponsors of the managed competition model.

There is substantial evidence that newer systems are promoting tighter integration of insurance and delivery, with the intent of offering higher-value care at a lower price. This is happening in particular in the expensive Northern California setting. Sutter Health Plus, for example, is a new HMO-like product that will draw on

a network of twenty-one hospitals and thirteen medical groups in Northern California. Likewise, Canopy Health—an “alliance” between John Muir Health, Hill Physicians, Dignity Health, and others—is a provider-owned company that has established a network of some 4000 providers with the aim of offering a high-quality, HMO-like product. If combined with new regulatory architecture that better rewards competition, these networks represent the new architecture on which a form of managed competition could grow, with competition among distinct delivery systems serving as an alternative way of bringing down consumer costs to the relatively arbitrary model of price-setting.⁴⁴

In addition to expanding the range of networks to choose from, new regulations could make competition among networks more likely to result in lower medical prices and better quality care. Two main factors were responsible, UCLA’s Melnick argues, for the erosion of competitive marketplaces: first, regulations requiring managed care plans to pay for emergency treatments for enrollees (the “prudent layperson rule”), which compromised their ability to exclude high-cost hospitals from their networks; second, hospitals consolidated rapidly across different regions of the state and country and used their clout both to negotiate higher rates across the board and to compel health insurers to keep more expensive hospitals in their networks. As the number of acute care hospitals fell by more than twenty percent from the late 1990s to 2016, the number of hospitals belonging to multi-hospital systems grew by over sixty percent. Such systems are consistently able to negotiate higher rates system-wide, irrespective of the performance of their least efficient members.

To reverse these anti-competitive trends, Melnick and others recommend—either through legislation or legal action—prohibiting or discouraging “all-or-nothing” contracting and similar strategies that hospital consolidation has enabled.⁴⁵ Other pro-competitive options include limiting monopoly pricing for out-of-network emergency care, and only allowing balance and “surprise” billing

that conforms to a fixed percentage of Medicare’s rates rather than a percentage of commercial rates, which may be much higher. Such bills typically are presented after a patient seeks emergency room treatment or undergoes an elective procedure, either in a hospital or an ambulatory setting, in which the facility and the principal provider are in network but assisting personnel such as the anesthesiologist and radiologist are not.⁴⁶

Rate-setting in other states has depended on particular local factors and historical circumstances, either because of the features of their health care systems or favorable federal regulation. California may not be in the best position to emulate these states. By contrast, based on the marketplace changes that are already coming into focus, greater competition between organized networks may moderate prices and improve quality without causing the upheaval in the health care sector that full-scale price controls could entail.

Notes

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28. This list is adapted from Ateev Mehrotra et al., "Defining the Goals of Health Care Price Transparency: Not Just Shopping Around," *NEJM Catalyst*, June 26, 2018. This is an excellent guide to the goals of price transparency and the obstacles facing them.
29. See the good explanation in Ezekiel Emanuel, *Reinventing*

- American Health Care*, 2014.
30. See Richard Averill and Richard Fisher, "Introducing Competition and Price Transparency into the Medicare Payment System," <https://www.3mhisinsideangle.com/blog-post/introducing-competition-price-transparency-medicare-payment-system/>.
 31. See Mehrotra and De Brantes op.cit. Also David Sandman, NY State Health Foundation, "Comments on Proposed Rule to Make Hospital Charges Publicly Available," June 20, 2018; Patrick B. Miller et.al, "All-Payer Claims Databases: An Overview for Policymakers," *AcademyHealth*, May 2010.
 32. See Erin Trish, Schaeffer Center for Health Policy and Economics, USC, "Variation in Provider Payment by Public and Private Payers," California Assembly Select Committee on Health Care Delivery Systems and Universal Coverage, January 17, 2017.
 33. Trish, op.cit., based on Ginsburg, 2010.
 34. <http://www.modernhealthcare.com/article/20180319/NEWS/180319896/medpac-hospitals-medicare-margins-continue-to-drop>
 35. Richard M. Scheffler, Daniel R. Arnold, and Christopher M. Whaley, "Consolidation Trends in California's Health Care System: Impacts on ACA Premiums and Outpatient Visit Prices," *Health Affairs*, September 2018.
 36. Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, School of Public Health, University of California, Berkeley, "Consolidation in California's Health Care Market 2010-2016: Impact on Prices and ACA Premiums," March 26, 2018.
 37. Integrated Healthcare Association, "California Regional Health Care Cost & Quality Atlas," Fact Sheet, February 2018. See also Dolores Yanagihara, Angela Kline, and Jill Yegian, "Benchmarking California Health Care Quality and Cost Performance," IHA, July 2016.
 38. Employee Benefit Research Institute, "Health Care Reform: Managed Competition and Beyond," Issue Brief 135, March 1993; Alain C. Enthoven
 39. On this point, see Alain C. Enthoven and Laura A. Tollen, eds., *Toward a 21st Century Health System: The Contributions and Promise of Prepaid Group Practice*, San Francisco: Jossey-Bass, 2004.
 40. See Charles Phelps, *Health Economics* (2nd ed), Reading, MA: Addison-Wesley, pp.390-91; Glenn Melnick and J.M. Zwanziger, "State Health Care Expenditures Under Competition and Regulation, 1980-1991," *American Journal of Public Health* 85, 1995. After the erosion of managed care, in the early 2000s, the prevailing temper favored reforming health care delivery to reduce costs rather than focusing on the fees charge by healthcare providers. Fee-for-service payments, many argued, encouraged doctors and other medical professionals to perform too high a volume of procedures, tests, and other services and resulted in care delivery that was both inefficient and often needless. Dartmouth's John Wennberg's work on the wide variation in the volume of services delivered in different regions of the country, as well as the prices paid for them—absent evidence of underlying medical need—was strong evidence for this theory. Atul Gawande, in a much-read *New Yorker* article on the excessive volume of services delivered in McAllen, Texas, brought the argument against fee-for-service payment and the concept of wasted spending to the close attention of policymakers.
 41. Glenn A. Melnick, Katya Fonkych, and Jack Zwanziger, "The California Competitive Model: How Has It Fared, and What's Next?" *Health Affairs* 37(9), September 2018.
 42. For instance, the average hospital payment-to-cost ratio remained stable for Medicare, low for Medicaid, and growing for private payers between 1990 and 2009. At the beginning of this period, according to the American Hospital Association, Medicare paid 89.4 percent of costs and at the end 90.1 percent. At the same time, commercial payments rose from 124.4 percent to 134.1 percent. Kominski, *Changing the U.S. Health System*, p. 251.
 43. See Micah Weinberg and Leif Wellington Haase, "Health Care Reform in the Balance: California and the Future of the Affordable Care Act," March 2018.
 44. Alain C. Enthoven and Lawrence C. Baker, "With Roots In California, Managed Competition Still Aims To Reform Health Care," *Health Affairs*, September 2018. Stanford University has operated a managed competition model for its employees since 1992, with some success at keeping down premiums and encouraging participation in lower-cost HMO options, though these characteristics have become less pronounced in recent years. See Enthoven and Brian Talbott, "Stanford's Experience with Managed Competition," *Health Affairs*, November/December 2004.
 45. Catherine Ho, "California Bill Aimed at Lowering Health Care Costs Gets Shelved," *San Francisco Chronicle*, June 26, 2018, <https://www.sfchronicle.com/business/article/California-bill-aimed-at-lowering-health-care-13027648.php>
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